





The Centers for Medicare and Medicaid Services:
SUPPORT Act Section 1003 Grant



SUD Technical Assistance Webinar Series



VIRGINIA MEDICAID: 24—

ASAM CRITERIA ASSESSMENT

DIMENSION 3

PAUL BRASLER, LCSW

APRIL 12 & 13, 2021

Department of Medical Assistance Services

Welcome and Meeting Information

- WebEx participants are muted
 - Please use Q&A feature for questions
 - Please use chat feature for technical issues
- Focus of today's presentation is practice-based – please Contact SUD@dmass.virginia.gov with technical or billing questions
- SUPPORT 101 Webinar Series slide decks are available on the DMAS ARTS website – www.dmass.virginia.gov/#/ARTS
- We are unable to offer CEUs for this webinar series

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CSM Disclaimer

The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$4,997,093 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

SUPPORT Team Disclaimer

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- ▶ The ASAM dimensions are designed to guide the assessment process and ensure that each client receives the most appropriate, individualized treatment. A clear understanding of these treatment assessment dimensions is critical for providers, Managed Care Organizations and other professionals in order to operationalize this content in practice with Medicaid members who have a substance use disorder
- ▶ **PLEASE NOTE** that the goal of this training is to help raise providers' awareness and understanding around implementing ASAM Treatment Assessment dimensions. This training is not designed as a substitute for official ASAM training, nor is this to serve as a substitute for any ASAM training that is required by any local, state, or federal regulatory agency or certifying organization. **This training is not sponsored or endorsed by ASAM**

Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven't already, before the start of today's webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey.

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a \$50 Amazon gift card as well as participation in the post-webinar survey will enter you into another \$50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!

Naloxone Resources

- ▶ Get trained now on naloxone distribution
 - REVIVE! Online training provided by DBHDS every Wednesday
 - <http://dbhds.virginia.gov/behavioral-health/substance-abuse-services/revive/lay-rescuer-training>
 - <https://getnaloxonenow.org/>
 - Register and enter your zip code to access free online training
- ▶ Medicaid provides naloxone to members at no cost and without prior authorization!
- ▶ Call your pharmacy before you go to pick it up!
- ▶ Getting naloxone via mail
 - Contact the Chris Atwood Foundation
 - <https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422>
 - Available only to Virginia residents, intramuscular administration

SUPPORT Act Grant Website -

<https://www.dmas.virginia.gov/#/artssupport>

SUPPORT Act Grant Overview

The Virginia Department of Medical Assistance Services (DMAS) was awarded the Centers for Medicare & Medicaid Services SUPPORT Act Section 1003 Grant in September 2019. The purpose of this grant is to decrease substance use disorder (SUD) provider workforce barriers and increase the treatment capacity of providers participating under the state Medicaid program to provide SUD treatment or recovery services.

Grant Goals

- Learn from Addiction and Recovery Treatment Services (ARTS) program
- Decrease barriers to enter workforce
- Focus on specific subpopulations: justice-involved members and pregnant and parenting members
- Maintain our core values: person-centered, strengths-based, recovery-oriented

Grant Components

- Needs assessment
- Strengths-based assessment
- Activities to increase provider capacity

Period of Performance

September 2019 - September 2021

Grant Email

SUPPORTgrant@dmas.virginia.gov

Information

- Virginia Medicaid Agency Awarded Federal Grant to Combat Opioid Crisis [pdf]
- Summary of Virginia's SUPPORT Act Goals and Activities [pdf]
- Accessibility Notice [pdf]

Resources

- UCSF National Clinician Consultation Center Warmline [pdf]
- COVID-19 Resource Library [pdf]

Monthly Stakeholder Meetings

- October 2020 [pdf]
- September 2020 [pdf]
- August 2020 [pdf]
- July 2020 [pdf]
- June 2020 [pdf]
- May 2020 [pdf]
- April 2020 [pdf]
- March 2020 [pdf]

Fall 2020 Webinars

- Video: How to Set Up a Preferred OBOT Webinar
- Slide Deck: How to Set Up a Preferred OBOT Webinar [pdf]
- Video: Hepatitis C Treatment Webinar
- Slide Deck: Hepatitis C Treatment Webinar [pdf]
- Fall 2020 Webinar Schedule [pdf]

SUPPORT 101 Webinars

- Session Twenty: "Novel" Substances [pdf]
- Session Nineteen: SUD & LGBTQ+ Clients [pdf]
- Session Eighteen: SUD & Legally-Involved Clients [pdf]
- Session Seventeen: Alcohol & Cannabis [pdf]
- Session Sixteen: SUD and The Family [pdf]
- Session Fifteen: SUD & Cultural Humility [pdf]
- Session Fourteen: Addressing SUD Stigma and Building Provider Empathy [pdf]
- Session Thirteen: Group Therapy Skills [pdf]
- Session Twelve: Individual Therapy Skills [pdf]
- Session Eleven: Co-Occurring Disorders [pdf]
- Session Ten: Screening and Assessment for SUD [pdf]
- Session Nine: SUD Treatment Introduction [pdf]
- Session Eight: Opioids and Stimulants Overview [pdf]
- Session Seven: Substance Use Disorders (SUD) Overview [pdf]
- Session Six: Providing Trauma-Informed Care [pdf]
- Session Five: Withdrawal Syndromes [pdf]
- Session Four: Crisis and Deescalation [pdf]
- Session Three: Suicide Assessment and Screening [pdf]
- Session Two: Client Engagement [pdf]
- Session One: Tele-Behavioral Health in the time of COVID-19 [pdf]
- Dr. Mishka Terplan - Pregnant and Postpartum Care for SUD during COVID-19 [pdf]
- Dr. Mishka Terplan - HIV and HCV Updates [pdf]
- Dr. Mishka Terplan - Chronic Pain and Addiction Treatment [pdf]

Hamilton Relay Transcriber (CC)

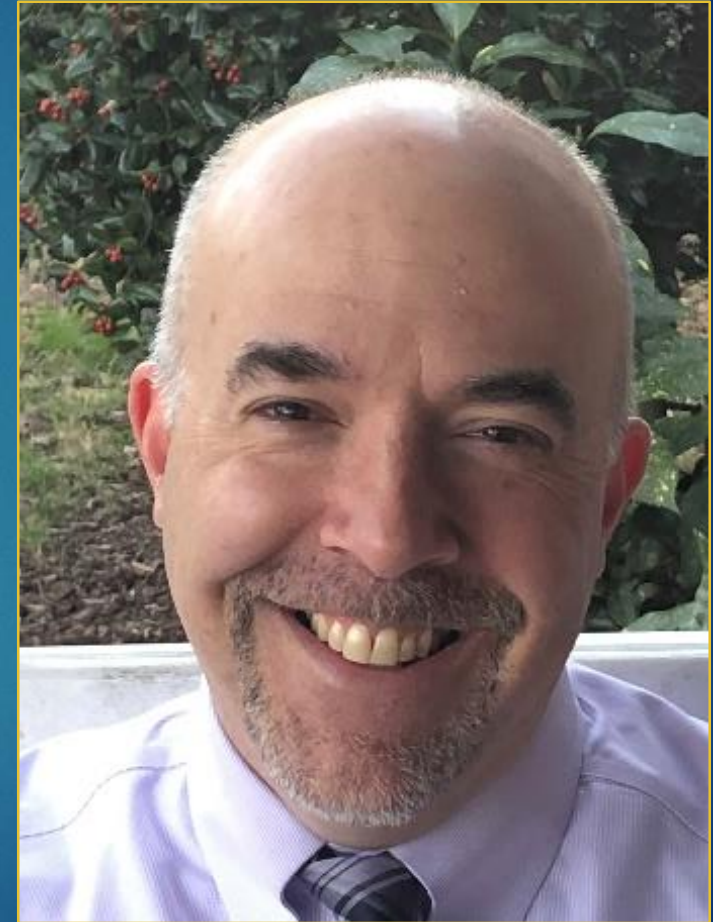
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- ▶ The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.
- ▶ We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.
- ▶ The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.

Today's Presenter

Paul Brasler, MA, MSW, LCSW
Behavioral Health Addiction Specialist, DMAS

Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.



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ARTS Billing Questions

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First Things First...

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- ▶ Even the best assessment policy, process, tools or forms cannot replace an empathetic, trained provider
- ▶ Prior to even thinking about doing an assessment, we need to agree:
 - ▶ People are worthy of help, have the right to self-determination, and should be treated with respect and dignity
 - ▶ Our role is to walk with our clients; not live their lives for them, and to respect their choices, even when those choices are things we disagree about
 - ▶ No one sets out to become addicted to substances or behaviors
 - ▶ Recovery is possible and is defined by the client


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Language

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- ▶ We want to use “Person-Centered language”
 - ▶ Not “Addict,” but **Person who uses drugs** or **Person with a substance use/behavioral disorder**
 - ▶ Not “Addiction,” but **Substance Use Disorder (SUD)**
 - ▶ Not “Abuse,” but **Use**
 - ▶ Not “Clean,” but **In Recovery** or **Testing Negative**
 - ▶ Not “Dirty,” but **Testing Positive**
 - ▶ Not “Relapse,” but **Return to Use**
- ▶ At the same time, out of habit, I may inadvertently use some of these older words/terminology—and some of the sources I quote use older terms
- ▶ Be cognizant that some people may describe themselves as “alcoholics,” “junkies,” etc., or may refer to “clean time” as how long they have been in recovery (and we need to respect this)



A Brief Word on SUD Treatment

People with SUD may engage and dis-engage in treatment during their illness; knowledge gained during treatment can be cumulative, therefore this back-and-forth pattern should not be viewed as treatment failure

Why ASAM (American Society of Addiction Medicine) Criteria?

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“The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions has its roots in the mid-1980s and was designed to help clinicians, payers, and regulators use and fund levels of care in a person-centered and individualized treatment manner. To increase access to care and improve the cost-effectiveness of addiction treatment, the ASAM Criteria represents a shift from [italics in original]:

(con’t)

Why ASAM (American Society of Addiction Medicine) Criteria?

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- ▶ One-dimensional to multidimensional assessment—from treatment based solely on diagnosis to treatment that addresses multiple needs
- ▶ Program-driven to clinically and outcome-driven treatment—from placement in a program often with fixed lengths of stay to person-centered, recovery-oriented, individualized treatment response to specific needs and progress and outcomes in treatment
- ▶ Fixed length of service to a variable length of service, based on patient needs and outcomes; and
- ▶ A limited number of discrete levels of care to a broad and flexible continuum of care in a chronic disease management system of care” (Herron & Brennan, 2020, p. 172)

ASAM Criteria Levels of Care

Level of Care	Description (Herron & Brennan, 2020, pgs. 174 – 175)
4.0	Medically managed intensive inpatient. 24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3; counseling available to engage patient in treatment
3.7	Medically monitored intensive inpatient. 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3; 16 hours per day for counselor availability
3.5	Clinically managed high-intensity residential treatment. 24-hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment; able to tolerate and use a full active milieu or therapeutic community
3.3	Clinically managed-population-specific high-intensity residential. 24-hour care with trained counselors to stabilize multi-dimensional imminent danger; less intense milieu and group treatment for those with cognitive or other impairments unable to use a full active milieu or therapeutic community
3.1	Clinically managed low-intensity residential. 24-hour structure with available trained personnel with emphasis on re-entry to the community; at least 5 hours of clinical service per week
2.5	Partial Hospitalization. 20 hours of service or more per week in a structured program for multi-dimensional instability not requiring 24-hour care
2.1	Intensive Outpatient. 9 hours of service or more per week (adults); 6 hours or more per week (adolescents) in a structured program to treat multi-dimensional instability
1.0	Outpatient Services. Less than 9 hours of service per week (adults); <6 hours per week (adolescents) for recovery or motivational enhancement therapies/strategies

ASAM Criteria Assessment Dimensions

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- ▶ ASAM exists to provide best-practices guidance for SUD providers in all treatment settings
 - ▶ This includes guidance on how to conduct a comprehensive assessment for all clients receiving SUD treatment
- ▶ **There is not a specific ASAM Assessment form or template**
- ▶ Instead ASAM outlines **six criteria dimensions** that should be a part of every SUD assessment to ensure that the client's needs are identified and met

ASAM Criteria Assessment Dimensions

(Herron & Brennan, 2015, p. 174)

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Assessment Dimensions	Assessment & Treatment Planning Focus
1. Acute intoxication and/or withdrawal potential	Assessment for intoxication or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services
2. Biomedical conditions and complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services

ASAM Criteria Assessment Dimensions

(Herron & Brennan, 2015, p. 174)

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Assessment Dimensions	Assessment & Treatment Planning Focus
3. Emotional, behavioral, or cognitive conditions and complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change

ASAM Criteria Assessment Dimensions

(Herron & Brennan, 2015, p. 174)

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Assessment Dimensions	Assessment & Treatment Planning Focus
5. Relapse, continued use, or continued problem potential	Assess readiness for relapse prevention services and teach where appropriate. Identify previous periods of sobriety or wellness and what worked to achieve this. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies
6. Recovery environment	Assess need for specific individualized family or significant others, housing, financial, vocational, educational, legal, transportation, childcare services. Identify any supports and assets in any or all of the areas



Comprehensive assessment of the patient is critical for treatment planning



However, completion of all assessments should not delay or preclude initiating pharmacotherapy for opioid use disorder



If not completed before initiating treatment, assessments should be completed soon thereafter

ASAM Assessment Recommendations (ASAM, 2020, p. 26)

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Assessment Criteria

Dimension 3

**EMOTIONAL, BEHAVIORAL, OR COGNITIVE
CONDITIONS AND COMPLICATIONS**

Assessment Criteria Dimension 3

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- ▶ Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications
- ▶ Treatment provided within the level of care or through coordination of mental health services

Recommendation

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- ▶ Time constraints limit how much information I can provide
- ▶ To fully understand this criteria dimension, I recommend you review the following webinars (which can be found on our website):
 - ▶ 3 Suicide
 - ▶ 6 Trauma-Informed Care
 - ▶ 11 Co-Occurring Disorders

Assessment Overview

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- ▶ All clients should receive a comprehensive behavioral health assessment as part of the treatment process, regardless of the service setting
- ▶ Assessing clients includes **four primary areas** (plus an additional two areas if time permits) of focus:
 - A. Suicide/Lethality Assessment**
 - B. Substance Use Assessment**
 - C. Mental Status Exam**
 - D. Basic Trauma Assessment**
 - E. Medical & Mental Health History
 - F. Family & Social History

Mental Status Exam

Examines the following

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- ▶ Appearance
- ▶ Attitude
 - ▶ Rapport
- ▶ Behaviors
- ▶ Mood
- ▶ Affect
 - ▶ Range of expression
- ▶ Speech
 - ▶ Volume
 - ▶ Rate
- ▶ Thought process
- ▶ Thought content
 - ▶ Delusions
 - ▶ Hallucinations
 - ▶ Obsessions
- ▶ Cognition
 - ▶ Orientation
 - ▶ Memory
- ▶ Reliability
- ▶ Insight
- ▶ Judgement

Mental Status Exam: Appearance

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- ▶ **Age**

- ▶ Does the client appear his/her stated age?

- ▶ **Height & weight**

- ▶ Does the client appear to be malnourished?

- ▶ **Sex** (include gender expression and gender identification if different from biological sex)

- ▶ **Ethnicity** an/or cultural identity

- ▶ Overall level of **hygiene and presentation**

- ▶ Is the client malodorous?

- ▶ **Manner of dress**

- ▶ Congruent with the season/weather?

- ▶ Any signs of **injury**?

MSE: Rapport

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- ▶ **Rapport:** The client's approach to the interview process and clinician
- ▶ The most subjective element of the mental status examination; **attitude**, depends on the interview situation, the skill and behavior of the clinician, and any pre-existing interactions between the clinician and the patient
- ▶ The patient's attitude may be described as **cooperative, uncooperative, hostile, guarded, suspicious** or **regressed**
- ▶ Attitude is important for the clinician's evaluation of the **quality of information obtained** during the assessment

MSE: Behavior

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- ▶ **Stereotypies:** Repetitive purposeless movements such as rocking or head banging
- ▶ **Mannerisms:** Repetitive quasi-purposeful abnormal movements such as a gesture or abnormal gait may be a feature of chronic schizophrenia or autism
- ▶ **Eye contact:** Quality of eye contact can provide clues to the client's emotional state
 - ▶ Repeatedly glancing to one side can suggest that the patient is experiencing hallucinations
 - ▶ Lack of eye contact may suggest depression, schizophrenia or autism spectrum disorder

MSE: Behavior

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- ▶ **Abnormalities of behavior**, also called abnormalities of activity, include observations of specific abnormal movements, as well as more general observations of the patient's level of activity and arousal. This can include:
 - ▶ Gait
 - ▶ Tremors
 - ▶ Tics
- ▶ Any evidence of **Catatonia**:
 - ▶ **Echopraxia**: Involuntary imitation of other person's movements or actions
 - ▶ **Catalepsy**: A medical condition characterized by a trance or seizure with a loss of sensation and consciousness accompanied by rigidity of the body
 - ▶ **Waxy flexibility**

MSE: Behavior

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- ▶ More **global behavioral abnormalities** may be noted, such as an increase in arousal and movement (described as ***Psychomotor agitation*** or ***Hyperactivity***) which might reflect mania or delirium
- ▶ An inability to sit still might represent **Akathisia**: A feeling of inner restlessness and a need to constantly move, a side effect of antipsychotic medication
- ▶ Similarly a global decrease in arousal and movement (described as ***psychomotor retardation, akinesia*** [muscle rigidity] or ***stupor*** [person is entirely unresponsive]) might indicate depression or a medical condition such as Parkinson's disease, dementia or delirium

MSE: Mood

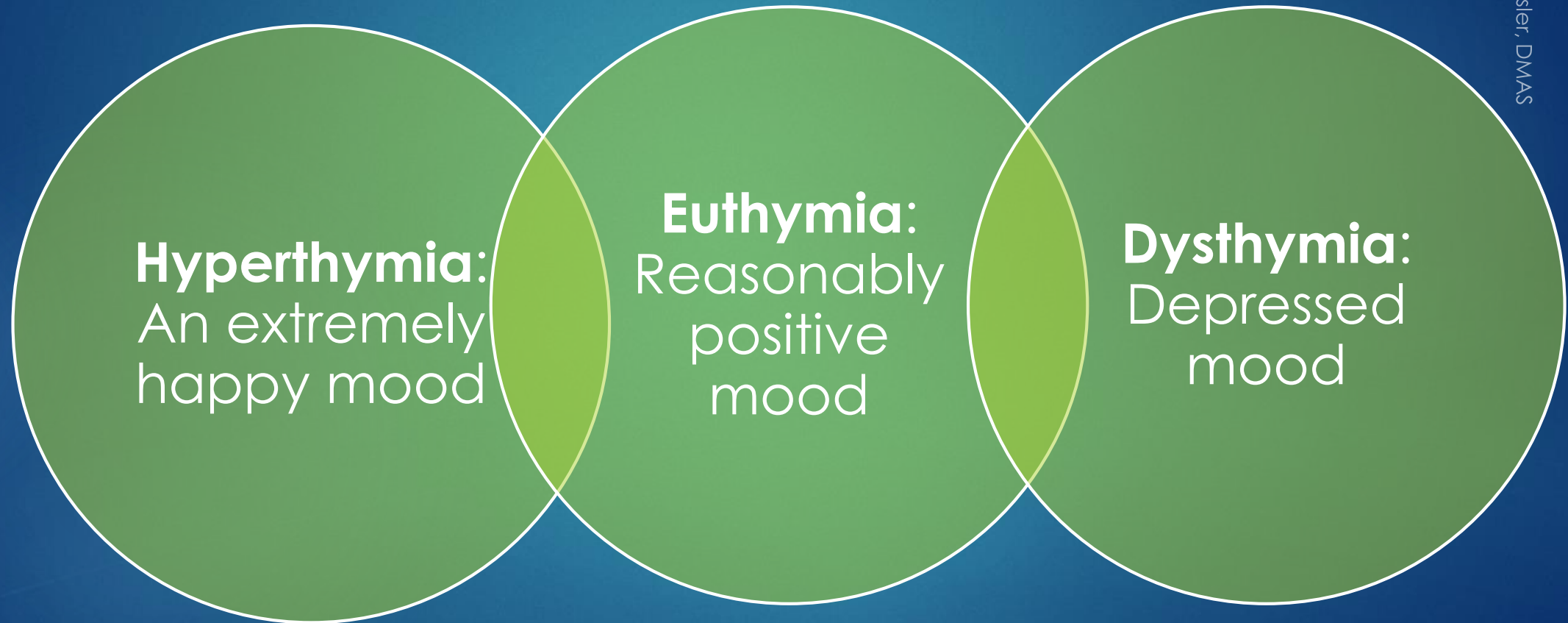
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- ▶ A **subjective** state based on how the client says that they feel and observations from the clinician
- ▶ **Mood** is often described using the patient's own words, but can also be described in summary terms such as ***euthymic, depressed, sad, euphoric, angry, anxious*** or ***apathetic***
- ▶ **Alexithymic** individuals may be unable to describe their subjective mood state
- ▶ An individual who is unable to experience any pleasure may be suffering from **Anhedonia**

MSE: Mood Continuum

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MSE: Affect

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- ▶ **Objective** when compared to the subjective description of mood
- ▶ **Largely based on clinical observations of the client**
- ▶ Some of the same words are used (e.g., sad, depressed, euthymic, etc.), but the following **parameters** are also used:
 - ▶ **Congruent** or **incongruent** with their thought content (e.g., someone shows a bland affect or is nonchalant when discussing a recent traumatic event)
 - ▶ **Mobility/lability**: The extent to which affect changes during the interview: the affect may be described as **labile**, **constricted**, or **fixed**

MSE: Affect Range of Expression

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- ▶ **Expansive affect:** Exaggerated emotions, often seen in the presence of a manic or hypomanic episode
- ▶ **Euthymic:** Stable, WNL affect
- ▶ **Constricted:** The patient demonstrates a euthymic range of emotions, but the emotions are not strong; often seen in people with depression or posttraumatic stress disorder
- ▶ **Blunted:** A very limited range of emotions; seen with a variety of mood disorders, trauma disorders and psychotic disorders
- ▶ **Flat:** Little to no expression of emotions; mainly seen in people with severe Major Depressive Disorder with or without psychotic features and schizophrenia

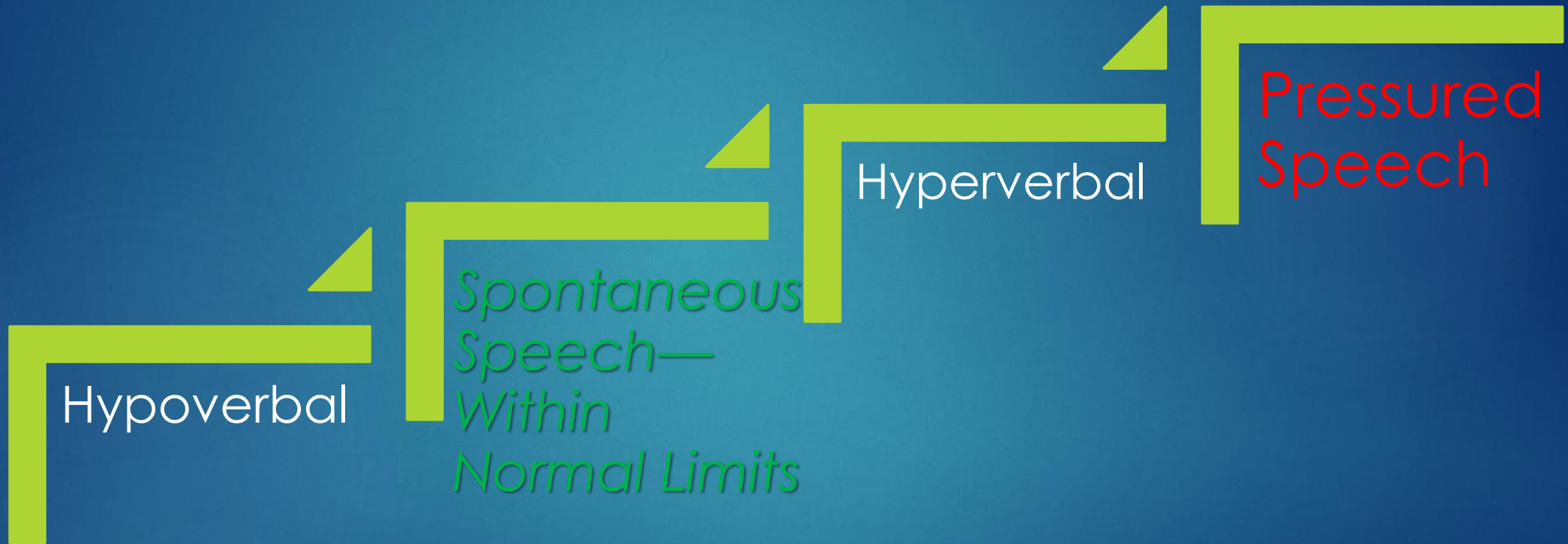
MSE: Speech

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- ▶ Production: Spontaneous speech as “typical” speech
- ▶ **Volume**
- ▶ **Rate:** Overly rapid or slow speech can indicate problems
- ▶ Specific features:
 - ▶ **Pressured speech** is common in people who are in a manic state
 - ▶ **Echolalia** (repetition of another person's words) AND
 - ▶ **Palladia** (repetition of the subject's own words) can be heard with patients with autism, schizophrenia or Alzheimer's disease

MSE: Speech Continuum

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MSE: Thought Process

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- ▶ Thought process cannot be directly observed, and can only be described by the patient, or **inferred from a patient's speech**
- ▶ The disorganization of normal thought processes is broadly referred to as **formal thought disorder**
 - ▶ Formal thought disorder is a common feature of psychosis
 - ▶ These abnormalities in formal thought processes can be thought of as falling on a “linear” continuum from goal directed to severely compromised



MSE: Thought Process

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- ▶ **Circumstantial:** Loss of capacity for goal-directed thinking; the client brings in many details, but usually gets back to the main point
- ▶ **Tangential:** The client pursues thoughts stimulated by various external or internal stimuli, usually with understandable associations, but never returns to the original point
- ▶ **Loose Associations:** Shifting of ideas from one to another with little to no logical connection; sometimes called derailment
- ▶ **Word Salad:** Language is nonsensical
- ▶ **Blocking:** Speech and train of thought is interrupted and picked up again in a few moments
- ▶ **Perseveration:** Needless repetition of the same thought or phrase in response to a prior stimuli

MSE: Thought Content

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- ▶ The main theme of the client's focus
- ▶ Includes:
 - ▶ Obsessions and Preoccupations
 - ▶ **Delusions**
 - ▶ **Hallucinations**
 - ▶ Illusions
 - ▶ **Suicidal ideation**
 - ▶ **Homicidal ideation**
 - ▶ Depersonalization/Derealization

MSE: Thought Disorder Continuum

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Preoccupations

Obsessions

Delusions

MSE: Thought Content— Preoccupations

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- ▶ Thoughts which are not fixed, false or intrusive, but have an undue prominence in the person's mind
- ▶ Clinically significant preoccupations include thoughts of suicide, homicide, suspicious or fearful beliefs associated with certain personality disorders, depressive beliefs (for example that one is unloved or a failure), phobias, or the cognitive distortions of anxiety and depression

MSE: Thought Content— Obsessions

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- ▶ **Obsessions:** An *Overvalued idea*; a false belief that is held with conviction but not with delusional intensity
- ▶ An **Obsession** is an "undesired, unpleasant, intrusive thought that cannot be suppressed through the patient's volition" (Dr. Bruce Stevens)
- ▶ Obsessions are typically intrusive thoughts of violence, injury, sex, obsessional doubt, or obsessive ruminations on intellectual themes (i.e., religion)
- ▶ **Hypochondriasis:** An obsession that one is suffering from an illness
- ▶ **Dysmorphophobia:** An overvalued idea that a part of one's body is abnormal, and people with anorexia nervosa may have an overvalued idea of being overweight

MSE: Thought Content— Delusions

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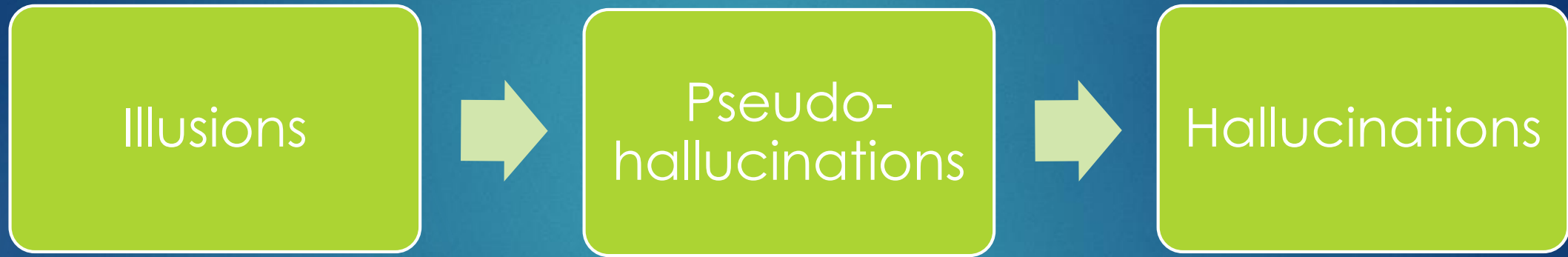
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- ▶ A **Delusion** is "a false, unshakeable idea or belief which is out of keeping with the patient's educational, cultural and social background ... held with extraordinary conviction and subjective certainty" (Dr. B. Stevens)
- ▶ The patient's delusions may be described as: ***Persecutory or paranoid, delusions of reference, grandiose, erotomantic, control, bizarre, jealousy, or misidentification of others***
- ▶ Delusions may be described as **mood-congruent** (the delusional content is in keeping with the mood), typical of manic or depressive psychoses, or **mood-incongruent** (the delusional content is not in keeping with the mood) which are more typical of schizophrenia

MSE: Thought Content— Perceptions

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- ▶ Any sensory experience, and the three broad types of perceptual disturbance are:



- ▶ An **Illusion** is defined as a false sensory perception in the presence of an external stimulus; in other words a distortion of a sensory experience, and may be recognized as such by the subject

MSE: Thought Content— Perceptions

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- ▶ A **Pseudo-hallucination** is experienced in internal or subjective space (for example as "voices in my head")
- ▶ **Auditory pseudo-hallucinations** are suggestive of dissociative disorders (e.g., Posttraumatic Stress Disorder and occasionally Borderline Personality Disorder)
- ▶ Many of the visual effects of hallucinogenic drugs are more correctly described as visual illusions or visual pseudo-hallucinations, as they are distortions of sensory experiences, and are not experienced as existing in objective reality

MSE: Thought Content— Perceptions

- ▶ A **Hallucination** is defined as a false sensory perception in the absence of any true external stimulus (i.e. *experienced by the client as real*)
- ▶ Hallucinations can occur in any of the five senses, although **Auditory** and **Visual** hallucinations are encountered more frequently than **Tactile** (touch), **Olfactory** (smell) or **Gustatory** (taste) hallucinations
- ▶ Any type of hallucination other than auditory is suspicious of organic conditions such as neurologic disorders, delirium, and drug intoxication or drug withdrawal syndromes, as well as malingering

MSE: Thought Content— Perceptions

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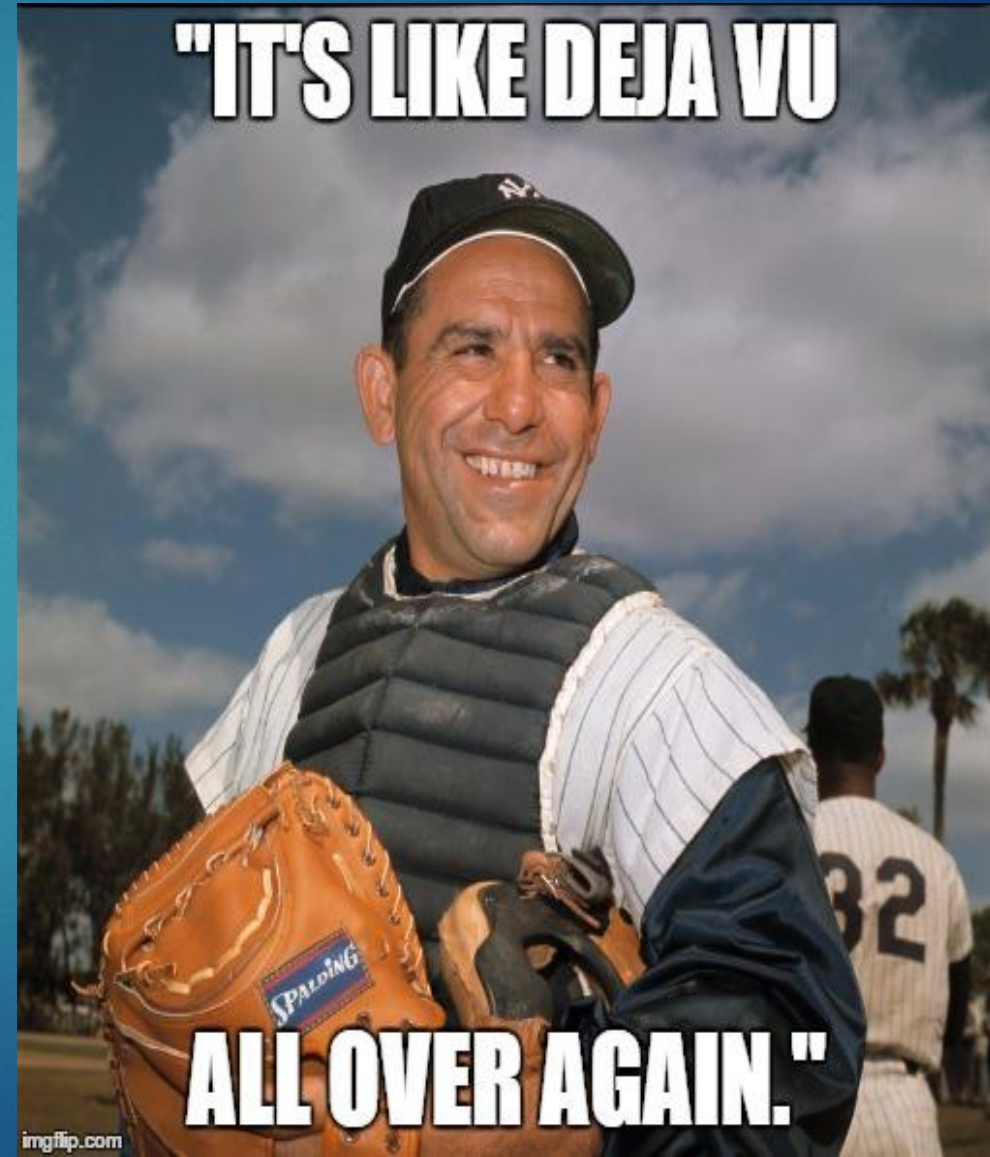
- ▶ **Third-person hallucinations:** Voices talking about the patient and hearing one's thoughts spoken aloud, *and*
- ▶ **Second-person hallucinations:** Voices talking to the patient, threatening, insulting or telling the client to commit suicide, may be a feature of depression with psychosis or schizophrenia
- ▶ *I always ask the client to point to where the voices are coming from in the room. If they point to their own heads, I become suspicious that the person's claims of hallucinating are valid—but I do take any statements of self-harm or harm to others seriously*

MSE: Thought Content— Perceptions

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Other sensory abnormalities include:

- ▶ **Déjà vu:** A distortion of the patient's sense of time
- ▶ **Depersonalization:** A distortion of the sense of self
- ▶ **Derealization:** A distortion of a sense of reality



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MSE: Cognition

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- ▶ **Alertness:** A global observation of **level of consciousness** (i.e. awareness of, and responsiveness to the environment; this might be described as **alert**, **clouded**, **drowsy**, or **stuporous**)
- ▶ **Orientation:** Assessed by asking the patient where he or she is (for example what building, town or state) and what time it is (time, day of the week, date), their name and the context or purpose for which they are meeting with you
- ▶ **Attention:** Measures the patient's ability to focus on the task at hand
- ▶ **Concentration:** Measures the client's ability to sustain focus over time (e.g., Serial Sevens test)

MSE: Cognition—Memory & Language

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- ▶ **Memory** is assessed in terms of:
 - ▶ **Immediate registration:** Repeating a set of words
 - ▶ **Short-term memory:** Recalling the set of words after an interval, or recalling a short paragraph
 - ▶ **Long-term memory:** Recollection of well-known historical facts
- ▶ **Language:** Assessed through the ability to name objects, repeat phrases, and by observing the individual's spontaneous speech and response to instructions

MSE: Reliability & Insight

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- ▶ **Reliability:** Accuracy, truthfulness, ability to give a consistent history
- ▶ **Insight:** The person's understanding of his or her mental illness is evaluated by exploring his or her explanatory account of the problem, and understanding of the treatment options
 - ▶ In this context, insight can be said to have three components: **Recognition** that one has a mental illness, **Compliance** with & motivation for treatment, and the **Ability** to re-label unusual mental events (such as delusions and hallucinations) as pathological
 - ▶ Impaired insight is characteristic of psychosis and dementia, and is an important consideration in treatment planning and in assessing the capacity to consent to treatment

MSE: Judgment

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- ▶ Refers to the client's capacity to make sound, reasoned and responsible decisions
- ▶ Contemporary practice is to inquire about how the patient has responded or would respond to real-life challenges and contingencies
- ▶ Assessment would take into account the individual's executive system capacity in terms of **impulsiveness, social cognition, self-awareness** and **planning ability**
- ▶ If a person's judgment is impaired due to mental illness, there might be implications for the person's safety or the safety of others

Additional Information

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The following additional items are not technically part of the mental status exam, but should also be asked as part of a comprehensive assessment as they impact the client's mental status:

- A. Mental health history**
- B. Quality of sleep**
- C. Appetite**



▶ **Mental Health Symptoms:**

- ▶ Duration
- ▶ Intensity

▶ **Treatment:**

- ▶ Type
- ▶ Duration
- ▶ Effectiveness

▶ **Medications:**

- ▶ Side-effects

▶ **Family history** of mental illness, including suicides, suicide attempts and psychiatric hospitalizations

Mental Health History

Appetite & Sleep

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Appetite:

- ▶ A decrease in appetite is a common symptom of depression
- ▶ “When is the last time you had something to eat?”
- ▶ “Have there been any changes to your appetite recently?”

Sleep:

- ▶ Sleep problems often precipitate many psychiatric problems and insomnia, or hypersomnia, are also common symptoms for a variety of mental health problems
- ▶ “Have there been any changes to your sleep recently?”

MSE: Cultural Considerations

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- ▶ There are potential problems when the MSE is applied in a cross-cultural context when the clinician and patient are from different cultural backgrounds
 - ▶ For example, the patient's culture might have different norms for appearance, behavior and display of emotions
- ▶ Culturally normative **spiritual and religious beliefs** need to be distinguished from delusions and hallucinations—these may seem similar to one who does not understand that they have different roots
- ▶ Cognitive assessment must also take the patient's language and educational background into account
- ▶ The clinician's racial bias (conscious and unconscious) is another potential issue to address

References

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